



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: THE SAN ANTONIO ORTHOPAEDIC SURGERY 400 CONCORD PLAZA SUITE 200 SAN ANTONIO TX 78216	MFDR Tracking #: M4-06-7102-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LUMBERMENS MUTUAL CASUALTY CO Box #: 21	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier paid the provider based on the M Code of No Mar. Under section 413.011 and 133.304 your company is obligated to pay F&R compensation. The documentation provided demonstrated the quality of care was delivered to the patient. Cost control has been achieved through our application of a reimbursement for services rendered. Our fees were determined using the Ingenix database, which is a nationally accepted database."

Amount in Dispute: \$39,000.23

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the hospital admission was not 'unusually costly' or 'unusually extensive' & therefore does not trigger the stop loss methodology as outlined in TDI-DWC rule 134.401. It is the carrier's position that bill was appropriately using the per-diem."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
03/25/2004	M, 866, 900, 958-002	ASC services for 29827	\$7105.43	\$0.00
	M, 866, 900	ASC services for 29824	\$7521.20	\$0.00
	M, 866, 900	ASC services for 29825	\$7998.80	\$0.00
	M, 866, 900	ASC services for 29822	\$7998.80	\$0.00
	M, 866, 900	ASC services for 29826	\$7886.00	\$0.00
	G, 857, 900	HCPCS code L8699	\$490.00	\$0.00
Total Due:			\$0.00	

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on June 25, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 21, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- M-No MAR.
- G-Unbundling.
- 857-Procedure included in another code billed on same date of service.

- 866-ASC reimbursement is based on fees established to be fair and reasonable in your geographical area.
 - 900-Based on further review, no additional allowance is warranted.
 - 958-002-ASC reimbursement is based on fees established to be fair and reasonable in your geographical area.
2. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states “Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements.”
 3. This dispute relates to ambulatory surgical care services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
 4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including “a copy of any pertinent medical records.” Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
 6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
 7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s rationale for increased reimbursement from the *Table of Disputed Services* states that “The carrier paid the provider based on the M Code of No Mar. Under section 413.011 and 133.304 your company is obligated to pay F&R compensation. The documentation provided demonstrated the quality of care was delivered to the patient. Cost control has been achieved through our application of a reimbursement for services rendered. Our fees were determined using the Ingenix database, which is a nationally accepted database.”
 - The requestor did not submit any copy from the Ingenix database to support their fees.
 - The requestor does not discuss or explain how additional payment of \$39,000.23 would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by

the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	2/14/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	2/14/2011
Authorized Signature	Health Care Business Management Director	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.